MEDI-CAL UPDATE Part 2
Billing and Policy
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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. Specific policy changes are detailed below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

DURABLE MEDICAL EQUIPMENT

Deleted Codes

HCPCS code A6551 (negative pressure wound therapy [NPWT] canister) has been deleted. All NPWT supplies must now be billed with revised code A6550 (negative pressure wound care set).

Codes E1019, E1021 and E1025 – E1027 (wheelchair accessories) have been deleted, and no replacement codes were created. Providers must use K0108 (other wheelchair accessories) to bill for these items.

Deleted and Replacement Codes

The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code
E0972	E0705
K0064	E2213
K0066	E2220
K0067	E2211
K0068	E2212
K0074	E2214
K0075	E2219
K0076	E2221
K0078	E2215
K0102	E2207
K0104	E2208
K0106	E2209
K0452	E2210

Approved *Treatment Authorization Requests* (TARs) for deleted codes must be revised to the new codes if the date of service is on or after November 1, 2006.

Billing Restrictions

HCPCS codes A4604 (heated tubing), A9281 (grabbing device), and E2371, E2372 and K0733 (wheelchair batteries) may only be purchased, and must be billed with modifier -NU (new purchase). Labor for replacement of these items is not separately reimbursable. Claims for A4604 require prior authorization and must include documentation of patient-owned equipment in the *Reserved For Local Use* field (Box 19) of the claim.

Codes E0170 and E0171 (bathroom equipment) require prior authorization. Providers must document on the TAR that the patient has a neuromuscular dysfunction or disease, or arthropathy of the hips and/or knees.

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

Codes A4604, A9281, E0170, E0171, E0641, E0642, E0705, E0911 and E0912 are taxable items.

HCPCS codes E0471 and E0472 (Bi-PAP devices) may now be purchased. Maximum reimbursement is $6,164.88.

Codes E0637, E0638, E0641 and E0642 (sit-to-stand and standing frames) require prior authorization and must be rented for a minimum of three months before a purchase may be authorized.

Reimbursement for code E1031 (rollabout chair) includes all options and accessories. Accessory codes are not separately reimbursable with this code to any provider if billed within the same month of service.

Reimbursement for codes E1037 – E1039 (transport chairs) includes all options and accessories except codes E0995 (elevating leg rests, each) and K0195 (elevating leg rests, pair). No accessory code except those for elevating leg rests is separately reimbursable with codes E1037 – E1039 to any provider if billed within the same month of service.

Code E1392 (portable oxygen concentrator) is a rental-only code and must be billed with modifier -RR (rental). The reimbursement rate includes all accessories, including batteries.

New wheelchair accessory HCPCS codes E2210 – E2215 and E2220 – E2226 are not separately reimbursable to any provider if billed for the same month of service as manual wheelchair base codes E1161, E1229, E1231 – E1238, K0001 – K0007 and K0009.

Purchase Frequency Restrictions
Code A4604 is limited to one in six months.

Codes E2211 – E2214 and E2218 – E2226 are limited to two in six months.

Codes E0705, E2207 and K0734 – K0737 are limited to one in 12 months.

Codes E2208, E2209, E2215, E2371, E2372 and K0733 are limited to two in 12 months.

Codes A9281, E0170, E0171, E0641, E0642, E0911 and E0912 are limited to one in three years.

All of the above restrictions are for any provider.

ORTHOTICS AND PROSTHETICS

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code(s)	Replacement Code(s)
K0618 – K0619	L0491 – L0492
K0630 – K0649	L0621 – L0640
K0670	L5858
L0860	L0859
L3963	L3971, L3973
L8210	A6542
L8230	A6544

Purchase Frequency Restrictions
Code A6542 is limited to three pair or six individual stockings in six months, same provider.

Code A6544 is limited to two in six months, any provider.

Codes L0491, L0492 and L0859 are limited to one in six months, same provider.

Codes L0621, L0623, L0625 – L0628, L0630, L0631, L0633, L0635, L0637, L0639 and L2387 are limited to two in 12 months, any provider.

Codes L0622, L0624, L0629, L0632, L0634, L0636, L0638 and L0640 are limited to two in three years, any provider.

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

Codes L2034, L3671 – L3673, L3702, L3763 – L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975 – L3978, L5703, L5858, L5971, L6621, L6677, L6883 – L6885 and L7400 – L7405 are limited to one in 12 months, same provider.

Billing Restrictions
Codes L2036 – L2038 (knee orthoses) are no longer reimbursable to podiatrists.

Codes L2034, L2387, L3671 – L3673, L3702, L3763 – L3766 and L3905 – L3976 may be billed as bilateral appliances.

A pair of orthotic shoes (i.e., two of single-shoe codes L3215 – L3217, L3219, L3221, L3222 and L3230) may be reimbursed on the same date of service, but claims must include a statement that at least one of the shoes is attached to a brace. The reimbursement rates for these codes have been revised due to the change in description from "pair" to "each."

Appliance addition codes will only be reimbursed when the base appliance has been provided. Addition codes may only be reimbursed separately if the item is being replaced or repaired.

Rate Revision for Orthotic Procedures
The reimbursement rate for code L2005 (knee orthosis) has been revised due to a correction to the Medicare rate.

The manual replacement pages reflecting these policies will be released in the October *Medi-Cal Update.*

DRUGS, INJECTIONS

New HCPCS Codes
The following HCPCS codes may be billed up to the amounts specified below:

Code	Description	Maximum Units
J0133	Acyclovir, 5 mg	300 units
J1451	Fomepizole, 15 mg	140 units
J2425	Palifermin, 50 mcg	140 units

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code(s)
Q0187	J7189
Q2022	J7188
Q4077	J3285
X1520	J7306
X6112	J1265
X6210	J1752
X6836	J0886
X7030	J0885
X7493	J0881 – J0882

Billing Restrictions
Claims for injection code A9535 (methylene blue) must include documentation to justify medical necessity when billed in excess of 20 ml.

HCPCS code C9225 (fluocinolone acetonide intravitreal implant [Retisert]) is reimbursable for patients with chronic non-infectious uveitis affecting the posterior segment of the eye. Claims require prior authorization.

Codes J0480 (basiliximab), J0795 (corticorelin ovine triflutate) and J1675 (histrelin acetate) require prior authorization.

Please see **CPT-4/HCPCS**, *page 4*

CPT-4/HCPCS *(continued)*

Injection code J0795 (corticorelin ovine triflutate) is reimbursable, with prior authorization, for patients with Cushing's Syndrome. ICD-9 diagnosis code 255.0 must be included on the TAR.

Injection codes J0881 – J0882 (darbepoetin) and J0885 – J0886 (epoetin) must be billed with one of the following ICD-9 diagnosis codes:

- J0881: 140.0 – 239.9 or a combination of V58.11 or V58.12 and 285.22 or 285.29
- J0882: 585.1 – 585.9, 586 or a combination of V56.0 – V56.8 and 285.21
- J0886: 585.6 or 285.21

Note: J0885 (epoetin, non-ESRD [end stage renal disease]) cannot be billed with ICD-9 code 585.6.

Injection code J1640 (hemin, 1 mg) may be reimbursed up to a maximum of 602 mg and is limited to females 10 years of age or older.

Injection code J2503 (pegaptanib) is reimbursable, with prior authorization, for patients with macular degeneration.

Claims for injection code J2504 (pegademase bovine) must be billed with ICD-9 diagnosis code 277.2 or 279.2.

Injection code J2850 (secretin, synthetic) is reimbursable, with prior authorization, for patients with Islets of Langerhans (ICD-9 code 157.4). The maximum dosage allowed is 48 mcg.

Injection code J3285 (treprostinil, 1 mg) is reimbursable, with prior authorization, for patients 16 years of age or older who have pulmonary heart disease.

Injection code J7306 (levonorgestrel implant system) is reimbursable for females 12 to 55 years of age. Claims require either a copy of the invoice or documentation of the invoice number and price in the *Reserved For Local Use* field (Box 19) of the claim form. Reimbursement is limited to once in three years. Providers billing for J7306 more than once in three years must document on the claim the necessity for the repeat implant.

Injection code J9225 (histrelin implant, 50 mg) is reimbursable only for males 30 years of age or older.

Injection code J9264 (paclitaxel protein-bound particles, 1 mg) may be reimbursed up to a maximum of 500 mg and must be billed with ICD-9 codes 174.0 – 175.9.

Injection code Q0515 (sermorelin acetate) requires a TAR. ICD-9 codes 253.0 – 253.9 must be included on the TAR.

Injection code Q4079 (natalizumab, 1 mg) must be billed with ICD-9 diagnosis code 340. Reimbursement is allowed up to a maximum of 300 mg.

The manual replacement pages reflecting these policies will be released in the October *Medi-Cal Update.*

Rental of Oxygen Stands

Effective for dates of service on or after October 1, 2006, HCPCS code E1355 (oxygen stand/rack) is reimbursable as a rental for up to three months, with prior authorization. Oxygen racks needed beyond three months are to be purchased. The monthly rental reimbursement for code E1355 is $4.36. *This information is updated on manual replacement pages dura 10 (Part 2) and dura cd 8 (Part 2).*

Primary Diagnosis Code Changes for GHPP Claims

Effective September 1, 2006, claims for reimbursement of Genetically Handicapped Persons Program (GHPP) services may be billed with a primary diagnosis code that reflects the condition for which the client seeks medical help. Previously, the primary diagnosis was limited to the ICD-9 code for the condition that qualified the client to participate in the Genetically Handicapped Persons Program.

For example, under the new policy if a client qualifies for GHPP due to cystic fibrosis (ICD-9 code 277.0) but presents to the doctor with the flu (ICD-9 code 487), then the code for the presenting condition would be entered as the primary diagnosis code. The code for cystic fibrosis would be entered as a secondary diagnosis.

This information is reflected on manual replacement pages genetic 5 and 6 (Part 2).

Rate Increase for Orthotic & Prosthetic Repair Labor

Effective for dates of service on or after October 1, 2006, the reimbursement rate for HCPCS code L4205 (repair of orthotic device, labor component, per 15 minutes) and L7520 (repair of prosthetic device, labor component, per 15 minutes) is $16.47. The hourly reimbursement rate is $65.88. Codes L4205 and L7520 may each be billed up to a maximum of three hours (12 units) of labor time without medical justification and prior authorization. However, these codes are also subject to the 90-day *Treatment Authorization Request* (TAR) thresholds for the cumulative costs of purchase, replacement and repair of orthotics ($250) and prosthetics ($500).

The updated information is reflected on manual replacement pages ortho 5 (Part 2), ortho cd1 30 (Part 2) and ortho cd2 22 (Part 2).

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71
238.72	238.73	238.74	238.75
238.76	238.79	277.30	277.31
277.39	284.01	284.09	284.1
284.2	288.00	288.01	288.02
288.03	288.04	288.09	288.4
288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64
288.65	288.69	289.53	289.83
323.01	323.02	323.41	323.42
323.51	323.52	323.61	323.62
323.63	323.71	323.72	323.81
323.82	331.83	333.71	333.72
333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19
338.21	338.22	338.28	338.29
338.3	338.4	341.20	341.21
341.22	377.43	379.60	379.61
379.62	379.63	389.15	389.16
429.83	478.11	478.19	518.7
519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11

Please see **ICD-9 Codes**, *page 6*

ICD-9 Codes *(continued)*

Additions (continued)

523.30	523.31	523.32	523.33
523.40	523.41	523.42	525.60
525.61	525.62	525.63	525.64
525.65	525.66	525.67	525.69
526.61	526.62	526.63	526.69
528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *
608.23 *	608.24 *	616.81 **	616.89 **
618.84 **	629.29 **	629.81 ** +	629.89 **
649.00 ** +	649.01 ** +	649.02 ** +	649.03 ** +
649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +
649.13 ** +	649.14 ** +	649.20 ** +	649.21 ** +
649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +
649.40 ** +	649.41 ** +	649.42 ** +	649.43 ** +
649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +
649.60 ** +	649.61 ** +	649.62 ** +	649.63 ** +
649.64 ** +	729.71	729.72	729.73
729.79	731.3	768.70 #	770.87 #
770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91
784.99	788.64	788.65	793.91
793.99	795.06 **	795.81	795.82
795.89	958.90	958.91	958.92
958.93	958.99	995.20	995.21
995.22	995.23	995.27	995.29
V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31
V58.32	V72.11	V72.19	V82.71
V82.79	V85.51	V85.52	V85.53
V85.54	V86.0 ** +	V86.1 ** +	

Restrictions

* Restricted to males only
** Restricted to females only
# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:
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dura cd 7/8
forms reo 1/2 *
genetic 5/6
ortho 5/6
ortho cd1 29/30
ortho cd2 21/22

* Pages updated due to ongoing provider manual revisions.